

Food and Drug Administration, HHS

§ 101.72

unfavorable information as well as favorable information, known to him/her to be pertinent to the evaluation of the proposed health claim.

(i) The petition shall be signed by the petitioner or by his/her attorney or agent, or (if a corporation) by an authorized official.

(j) *Agency action on the petition.* (1) Within 15 days of receipt of the petition, the petitioner will be notified by letter of the date on which the petition was received. Such notice will inform the petitioner that the petition is undergoing agency review and that the petitioner will subsequently be notified of the agency's decision to file for comprehensive review or deny the petition.

(2) Within 100 days of the date of receipt of the petition, FDA will notify the petitioner by letter that the petition has either been filed for comprehensive review or denied. The agency will deny a petition without reviewing the information contained in "B. Summary of Scientific Data" if the information in "A. Preliminary Requirements" is inadequate in explaining how the substance conforms to the requirements of § 101.14(b). If the petition is denied, the notification will state the reasons therefor, including justification of the rejection of any report from an authoritative scientific body of the U.S. Government. If filed, the date of the notification letter becomes the date of filing for the purposes of this regulation. If FDA does not act within such 100 days, the petition shall be deemed to be denied unless an extension is mutually agreed upon by FDA and the petitioner. A petition that has been denied, or has been deemed to be denied, without filing will not be made available to the public. A filed petition will be available to the public to the extent provided under paragraph (e) of this section.

(3) Within 90 days of the date of filing, FDA will by letter of notification to the petitioner:

(i) Deny the petition, or

(ii) Inform the petitioner that a proposed regulation to provide for the requested use of the health claim will be published in the FEDERAL REGISTER. If the petition is denied, the notification will state the reasons therefor, including justification for the rejection of

any report from an authoritative scientific body of the U.S. Government. FDA will publish the proposal to amend the regulations to provide for the requested use of the health claim in the FEDERAL REGISTER within 90 days of the date of filing. The proposal will also announce the availability of the petition for public review.

(iii) If FDA does not act within 90 days of the date of filing, the petition shall be deemed to be denied unless an extension is mutually agreed upon by FDA and the petitioner.

(4)(i) Within 270 of the date of publication of the proposal, FDA will publish a final rule that either authorizes use of the health claim or explains why the agency has decided not to authorize one.

(ii) For cause, FDA may extend, no more than twice, the period in which it will publish a final rule; each such extension will be for no more than 90 days. FDA will publish a notice of each extension in the FEDERAL REGISTER. The document will state the basis for the extension, the length of the extension, and the date by which the final rule will be published, which date shall be within 540 days of the date of receipt of the petition.

[58 FR 2534, Jan. 6, 1993; 58 FR 17097, Apr. 1, 1993, as amended at 59 FR 425, Jan. 4, 1994; 62 FR 28232, May 22, 1997; 62 FR 40599, July 29, 1997; 63 FR 26719, May 14, 1998; 63 FR 40024, July 27, 1998; 66 FR 56035, Nov. 6, 2001]

§ 101.71 Health claims: claims not authorized.

Health claims not authorized for foods in conventional food form or for dietary supplements of vitamins, minerals, herbs, or other similar substances:

(a) Dietary fiber and cardiovascular disease.

(b) Zinc and immune function in the elderly.

[58 FR 2534, Jan. 6, 1993, as amended at 58 FR 2548, 2578, 2620, 2639, 2664, 2714, Jan. 6, 1993; 58 FR 17100, Apr. 1, 1993; 59 FR 437, Jan. 4, 1994; 65 FR 58918, Oct. 3, 2000]

§ 101.72 Health claims: calcium, vitamin D, and osteoporosis.

(a) *Relationship between calcium, vitamin D, and osteoporosis.* An inadequate

intake of calcium or calcium and vitamin D contributes to low peak bone mass, which has been identified as one of many risk factors in the development of osteoporosis. Peak bone mass is the total quantity of bone present at maturity, and experts believe that it has the greatest bearing on whether a person will be at risk of developing osteoporosis and related bone fractures later in life. Another factor that influences total bone mass and susceptibility to osteoporosis is the rate of bone loss after skeletal maturity. Vitamin D is required for normal absorption of calcium and to prevent the occurrence of high serum parathyroid hormone (PTH) concentration, which stimulates mobilization of calcium from the skeleton and can lower bone mass. Calcium, along with vitamin D and several other nutrients, is required for normal bone mineralization. While vitamin D is required for optimal bone mineralization, it is more effective when calcium intake is adequate. An adequate intake of calcium and vitamin D is thought to exert a positive effect during adolescence and early adulthood in optimizing the amount of bone that is laid down. However, the upper limit of peak bone mass is genetically determined. The mechanism through which adequate intakes of calcium and vitamin D and optimal peak bone mass reduce the risk of osteoporosis is thought to be as follows. All persons lose bone with age. Hence, those with higher bone mass at maturity take longer to reach the critically reduced mass at which bones can fracture easily. The rate of bone loss after skeletal maturity also influences the amount of bone present at old age and can influence an individual's risk of developing osteoporosis. Maintenance of adequate intakes of calcium and vitamin D later in life is thought to be important in reducing the rate of bone loss particularly in the elderly and in women during the first decade following menopause, but a significant protective effect is also seen among men and younger women.

(b) *Significance of calcium or calcium and vitamin D.* Adequate calcium intake, or adequate calcium and vitamin D intake, is not the only recognized risk factor in the development of

osteoporosis, which is a multifactorial bone disease. Maintenance of adequate calcium and vitamin D intakes throughout life is necessary to achieve optimal peak bone mass and to reduce the risk of osteoporosis in later life. However, vitamin D is most effective in this regard when calcium intake is adequate. Increasing intake of calcium has been shown to have beneficial effects on bone health independent of dietary vitamin D.

(c) *Requirements.* (1) All requirements set forth in § 101.14 shall be met.

(2) *Specific requirements—(i) Nature of the claim.* A health claim associating calcium or, when appropriate, calcium and vitamin D with a reduced risk of osteoporosis may be made on the label or labeling of a food described in paragraphs (c)(2)(ii) and (d)(1) of this section, provided that:

(A) The claim makes clear the importance of adequate calcium intake, or when appropriate, adequate calcium and vitamin D intake, throughout life, in a healthful diet, are essential to reduce osteoporosis risk. The claim does not imply that adequate calcium intake, or when appropriate, adequate calcium and vitamin D intake, is the only recognized risk factor for the development of osteoporosis;

(B) The claim does not attribute any degree of reduction in risk of osteoporosis to maintaining an adequate dietary calcium intake, or when appropriate, an adequate dietary calcium and vitamin D intake, throughout life.

(ii) *Nature of the food.* (A) The food shall meet or exceed the requirements for a “high” level of calcium as defined in § 101.54(b);

(B) The calcium content of the product shall be assimilable;

(C) Dietary supplements shall meet the United States Pharmacopeia (USP) standards for disintegration and dissolution applicable to their component calcium salts, except that dietary supplements for which no USP standards exist shall exhibit appropriate assimilability under the conditions of use stated on the product label;

(D) A food or total daily recommended supplement intake shall not contain more phosphorus than calcium on a weight per weight basis.

(d) *Optional information.* (1) The claim may include the term “vitamin D” if the food meets or exceeds the requirements for a “high” level of vitamin D as defined in §101.54(b);

(2) The claim may include information from paragraphs (a) and (b) of this section.

(3) The claim may make reference to physical activity.

(4) The claim may include information on the number of people in the United States, including the number of people in certain subpopulations in the United States, who have osteoporosis or low bone density. The sources of this information must be identified, and it must be current information from the National Center for Health Statistics, the National Institutes of Health, or the National Osteoporosis Foundation.

(5) The claim may state that the role of adequate calcium intake, or when appropriate, the role of adequate calcium and vitamin D intake, throughout life is linked to reduced risk of osteoporosis through the mechanism of optimizing peak bone mass during adolescence and early adulthood. The phrase “build and maintain good bone health” may be used to convey the concept of optimizing peak bone mass. The claim may also state that adequate intake of calcium, or when appropriate, adequate intake of calcium and vitamin D, is linked to reduced risk of osteoporosis through the mechanism of slowing the rate of bone loss for persons with a family history of the disease, post-menopausal women, and elderly men and women.

(e) *Model health claims.* The following model health claims may be used in food labeling to describe the relationship between calcium and osteoporosis: Adequate calcium throughout life, as part of a well-balanced diet, may reduce the risk of osteoporosis.

Adequate calcium as part of a healthful diet, along with physical activity, may reduce the risk of osteoporosis in later life.

(f) *Model additional health claims for calcium and vitamin D.* The following model health claims may be used in food labeling to describe the relationship between calcium, vitamin D, and osteoporosis:

Adequate calcium and vitamin D throughout life, as part of a well-balanced diet, may reduce the risk of osteoporosis.

Adequate calcium and vitamin D as part of a healthful diet, along with physical activity, may reduce the risk of osteoporosis in later life.

[73 FR 56486, Sept. 29, 2008]

§ 101.73 Health claims: dietary lipids and cancer.

(a) *Relationship between fat and cancer.* (1) Cancer is a constellation of more than 100 different diseases, each characterized by the uncontrolled growth and spread of abnormal cells. Cancer has many causes and stages in its development. Both genetic and environmental risk factors may affect the risk of cancer. Risk factors include a family history of a specific type of cancer, cigarette smoking, alcohol consumption, overweight and obesity, ultraviolet or ionizing radiation, exposure to cancer-causing chemicals, and dietary factors.

(2) Among dietary factors, the strongest positive association has been found between total fat intake and risk of some types of cancer. Based on the totality of the publicly available scientific evidence, there is significant scientific agreement among experts, qualified by training and experience to evaluate such evidence, that diets high in total fat are associated with an increased cancer risk. Research to date, although not conclusive, demonstrates that the total amount of fats, rather than any specific type of fat, is positively associated with cancer risk. The mechanism by which total fat affects cancer has not yet been established.

(3) A question that has been the subject of considerable research is whether the effect of fat on cancer is site-specific. Neither human nor animal studies are consistent in the association of fat intake with specific cancer sites.

(4) Another question that has been raised is whether the association of total fat intake to cancer risk is independently associated with energy intakes, or whether the association of fat with cancer risk is the result of the higher energy (caloric) intake normally associated with high fat intake. FDA has concluded that evidence from